

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13199

Reg. Dist. No.

TO DEPARTMENT: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



X

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2

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>	c. LENGTH OF STAY IN b <i>all his life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke, md</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Home</i>	d. STREET ADDRESS <i>1619 Banks ST.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>JAMES</i>	First <i>JAMES</i> Middle <i>Anderson</i> Last <i>Anderson</i>	4. DATE OF DEATH Month <i>Nov.</i> Day <i>7</i> Year <i>1960</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>MAY 6, 1880</i>	9. AGE (In years at birth) <i>80 yrs.</i>	10. IF UNDER 4 YEARS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laboyer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>SAW-mill</i>	10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Anderson</i>	14. MOTHER'S MIDDLE NAME <i>Janie Wright</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <i>One found Ernest Anderson - Painter, Va.</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A fall followed by hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>General Physical Weakness</i> DUE TO (c) <i>Starvation</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell to floor against store - 2nd minor burns fract. bid.</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Pocomoke City, Worcester</i>	(County) (State) <i>Worcester, MD</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>Edgar Wharton Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <i>11/13/60</i>
EXAMINER'S NAME (Type) <i>N. E. Sartoris</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-14-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Falls Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Pocomoke, md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - New church, Va.</i>	ADDRESS <i>Elgar Wharton - New church, Va.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 16 '60</i>	24b. REGISTRAR'S SIGNATURE <i>C. L. & T. Inc.</i>	

STATE OF TEXAS - DEPARTMENT OF STATE AND LOCAL GOVERNMENT
EX-EMERGENCY REGULATIONS

20-601

ITEM	DESCRIPTION	AMOUNT	UNIT	STOCK NUMBER
1	1	1	1	1
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13230

CERTIFICATE OF DEATH

13200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			c. LENGTH OF STAY IN 1b 73 years					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Walnut Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LOLA MITCHELL BLADES			First LOLA	Middle MITCHELL	Last BLADES			
4. DATE OF DEATH November 17, 1960	Month November	Day 17	Year 1960	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1866	9. AGE (In years last birthday) 94 yrs.	Address 211 Walnut Street			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John A. Mitchell			14. MOTHER'S MAIDEN NAME Adaliza M. White					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	17. INFORMANT Miss Maude Blades, Pocomoke City, Md.	Address 211 Walnut Street				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pocomoke Elena</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Socia-Comatose state</i> DUE TO (c) <i>Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH Years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.	Month Nov	Day 16	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) Pocomoke City	(County) Worcester	(State) Maryland
21. I certify that I attended the deceased from <i>Aug 31, 1960</i> , to <i>Nov 17, 1960</i> , that I last saw the deceased alive on <i>Nov 16, 1960</i> , and that death occurred at <i>3 p.m.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>N. E. Sartorius, Sr.</i>						ADDRESS (Street, city or town, state) Pocomoke City, Md.	DATE SIGNED 11-18-60	
PHYSICIAN'S NAME (Type) N. E. SARTORIUS, SR.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-19-60	22c. NAME OF CEMETERY Bethany Methodist	22d. LOCATION (City, town, or county) Pocomoke City, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert H. Watson</i>	ADDRESS Pocomoke City, Md.	24a. REC'D BY REGISTRAR DATE NOV 21 '60	24b. REGISTRAR'S SIGNATURE Cirber L. Thrall					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

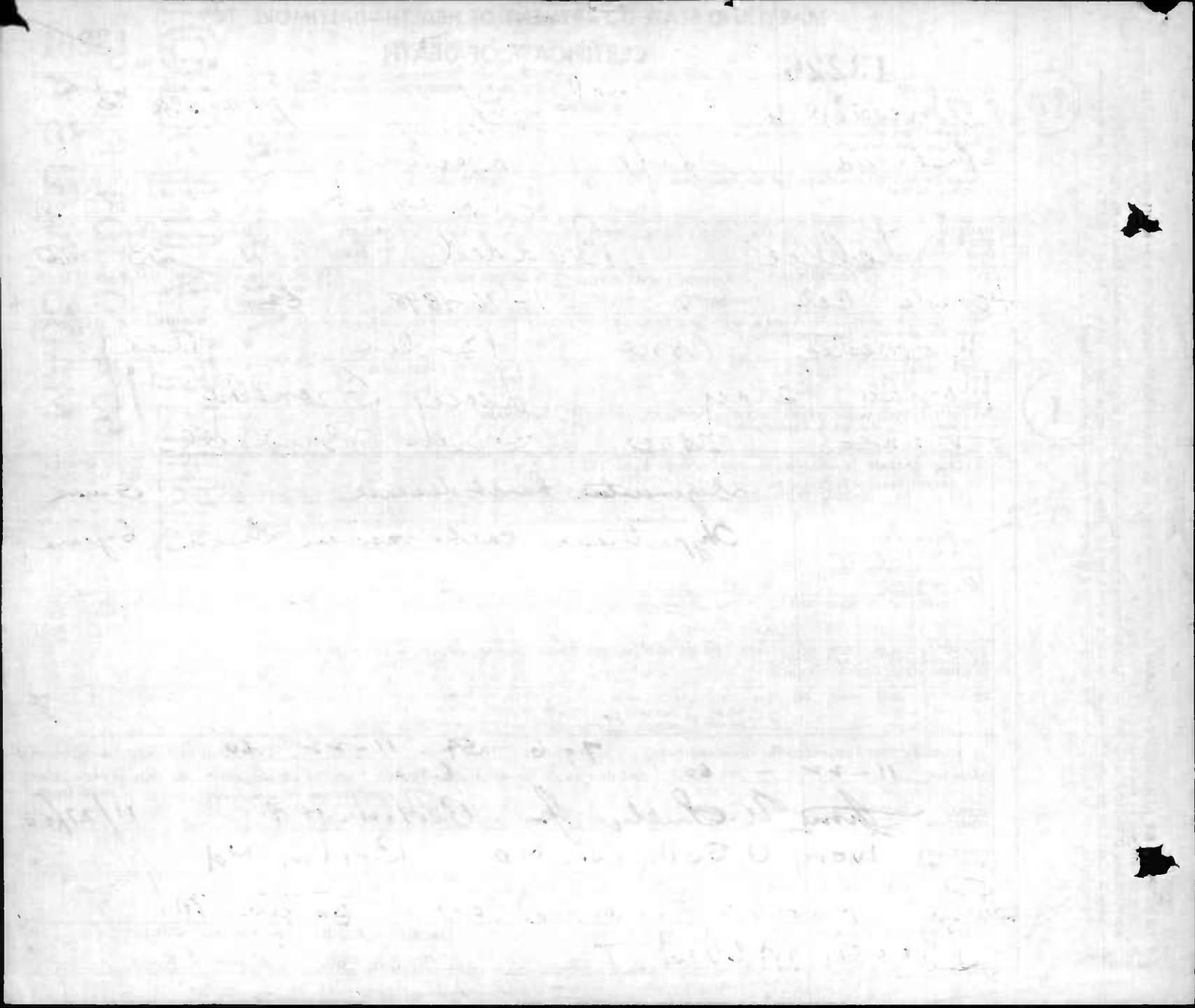
Reg. Dist. No.

13201

13226		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY <i>Worcester Co</i>		a. STATE <i>Maryland</i>	b. COUNTY <i>Worcester Co</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	
c. LENGTH OF STAY IN 1b <i>Life</i>		d. STREET ADDRESS <i>Flower St</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First (Type or print) <i>Lollie</i>		Middle <i>Breddell</i>	Last <i>Breddell</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-16-1898</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Berlin</i>		9. AGE (In years lost birthday) <i>62 yrs.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Wendy Gray</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Franklin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	INFORMANT <i>Irish Breddell</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO <i>Degenerative heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 mos</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Hypertension cardiovascular disease</i>		(c) <i>6 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7-6, 1957</i> to <i>11-22, 1964</i> that I last saw the deceased alive on <i>11-22, 1960</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ivory U. Sully, Jr., M.D.</i>	ADDRESS (Street, city or town, state) <i>Berlin, Md.</i>		DATE SIGNED <i>11/27/60</i>
PHYSICIAN'S NAME (Type) <i>Ivory U. Sully, Jr., M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>11-26-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Cemetery</i>	22d. LOCATION (City, town, or county) <i>Berlin, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker M. West</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 6 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The registrar may remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13238 13202
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN lb RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 3 Berlin		e. STREET ADDRESS R.F.D. 3 Berlin	
3. NAME OF DECEASED (Type or print) Mary		First A.	Middle Bridgell
Last Briddell		4. DATE OF DEATH November 18, 1960	Month Day Year
5. SEX F.	6. COLOR OR RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Robbins		14. MOTHER'S MAIDEN NAME Hettie Massey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Informant	
		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-vascular Disease</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO DUE TO DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sinility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs 10 mos</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Berlin, Md.	
ACTUAL SIGNATURE Ivory V. Shelly Jr. M.D.		DATE SIGNED 11/21/60	
PHYSICIAN'S NAME (Type) Ivory V. Shelly Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/22/1960	22c. NAME OF CEMETERY OR CREMATORIAL New Bethel
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart Salisbury Md.		22d. LOCATION (City, town, or county) Berlin	
		ADDRESS Berlin	24a. REC'D BY REGISTRAR NOV 28 1960
		DATE Arthur S. Trahan	24b. REGISTRAR'S SIGNATURE

HUNG HUANG HUA

20251

22 20-20 February 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13227

CERTIFICATE OF DEATH

13203

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b All his life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Flower Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin	
3. NAME OF DECEASED (Type or print) John H. Brittingham		First John	Middle H. Brittingham
4. DATE OF DEATH 11 23 1960	Month 11	Day 23	Year 1960
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1884
9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Canning	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Brittingham	14. MOTHER'S MAIDEN NAME Maggie Purnell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT Shumway Brittingham, Flower St., Berlin, Md	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension Cardiovascular Disease 6 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11-25	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-25 , 19 55 , to 11-21 , 19 60 , that I last saw the deceased alive on 11-21 , 19 60 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ivory U. Sully Jr.</i>	ADDRESS (Street, city or town, state) Berlin, Md		
PHYSICIAN'S NAME (Type) Ivory U. Sully, Berlin, Maryland	DATE SIGNED 11/25/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/26/60	22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Cem.	22d. LOCATION (City, town, or county) (State) Berlin, Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thornton B. Jolley, Salisbury, Md</i>	ADDRESS	24a. REC'D BY REGISTRAR NOV 30 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Lewis</i>

STATE OF CALIFORNIA

RECEIVED
MAY 20 1942

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FROM [REDACTED]

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FOR STATE
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13204

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill 23 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 323 Market St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Neale Claude Brittingham		First	Middle
4. DATE OF DEATH Novembe 25 1960		Last	Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Aug 19-1933		9. AGE (In years) IF UNDER 1 YEAR 27 3/16 Months Deys Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Splicer		10. KIND OF BUSINESS OR INDUSTRY Telephone Co	11. BIRTHPLACE (State or foreign country) Wilmington Del.
13. FATHER'S NAME Claude A. Brittingham		14. MOTHER'S MAIDEN NAME Marie E. Henman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or known) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Marie H. Brittingham, Snow Hill, md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STATUS EPILEPTICUS DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH minutes @ 20 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert C. La Mar, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11-25-60	
Address (Street, city, town, or county) Snow Hill, md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov 27 60		22b. DATE THEREOF Nov 27 60	
22c. NAME OF CEMETERY OR CREMATORIUM Wataopt Cemetery		22d. LOCATION (City, town, or country) (State) Snow Hill, md	
23. FUNERAL DIRECTOR Clay E. Dennis		24a. REC'D BY REGISTRAR DATE NOV 28 '60	
ADDRESS Snow Hill, md		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 7/59

infestation

heavy fall

abnormal

fall crop

fall crop

fall crop

fall damage less

00-08-1960

medium to heavy

light to none

Leaves

ADROMA LARVAL

leaves

BOLIVIANA COTATE

severe damage less

X

X

X

00-08-11

X

medium to none

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13239

CERTIFICATE OF DEATH

Reg. Dist. No. 13205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STOCKTON		c. LENGTH OF STAY IN 1b 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X STOCKTON		d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOVIE JEAN FOREMAN		First	Middle	Last	4. DATE OF DEATH NOV. 3rd 1960	Month	Day	Year	
5. SEX FEMALE		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MARCH 19 1864	9. AGE (In years last birthday) 96 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph BRITTINGHAM		14. MOTHER'S MAIDEN NAME MARY White							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Annie Robertson - Stockton, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Benignictosis						INTERVAL BETWEEN ONSET AND DEATH ?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Senility		(c) DUE TO Antherosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19 Nov 1864		20f. (City or town) Stockton		(County) Worcester	(State) Md.
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above. ACTUAL SIGNATURE N.E. Sartoris Jr. M.D.						ADDRESS (Street, city or town, state) Foreman Cem. 19 Nov 1960		DATE SIGNED 11/4/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-60		22c. NAME OF CEMETERY OR CREMATORIUM Foreman Cem.		22d. LOCATION (City, town, or county) Stockton, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va.		ADDRESS		24a. REC'D BY REGISTRAR NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

ST 39000148-017044 PCT/GB2018/052772 GB2018052772

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13206

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Laurel Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ALICE	Middle E.	Last GODWIN
4. DATE OF DEATH November 21 1960	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1879
9. AGE (In years from birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Robert Carlisle	14. MOTHER'S MAIDEN NAME Malinda Greenfield		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk.	16. SOCIAL SECURITY NO. ---	17. INFORMANT Walter F. Golt, Wilmington, Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 10 hrs.
<i>Coronary Thrombosis</i>			
<i>Congestive Heart Failure</i>			
<i>Hypertensive Cardiovascular Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-12- , 19 57 , to 11-20- , 19 60 , that I last saw the deceased alive on 11-20-1960 , and that death occurred at 3 A.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state) 801-4th St, Pocomoke, Md.		DATE SIGNED 11-21-60
ACTUAL SIGNATURE <i>Cecil A. Duverney</i>			
PHYSICIAN'S NAME (Type) Cecil A. Duverney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-25-60	22c. NAME OF CEMETERY OR CREMATORIUM Silverbrook Cemetery	22d. LOCATION (City, town, or county) Wilmington, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert H. Watson</i>	ADDRESS Pocomoke City, Md.	24a. REC'D. BY REGISTRAR DATE NOV 25 1960	24b. REGISTRAR'S SIGNATURE <i>John S. Turner</i>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEDERAL MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF
TENNESSEE

Official Title:

Office of the Coroner

Date of Birth:

Place and Date of Death: 10-18-1988

Place of Death: Hospital

Time of Death: 10:00 AM

Method of Death: Natural

Causes of Death: Heart Disease

Other Causes of Death: None

Other Information: None

TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

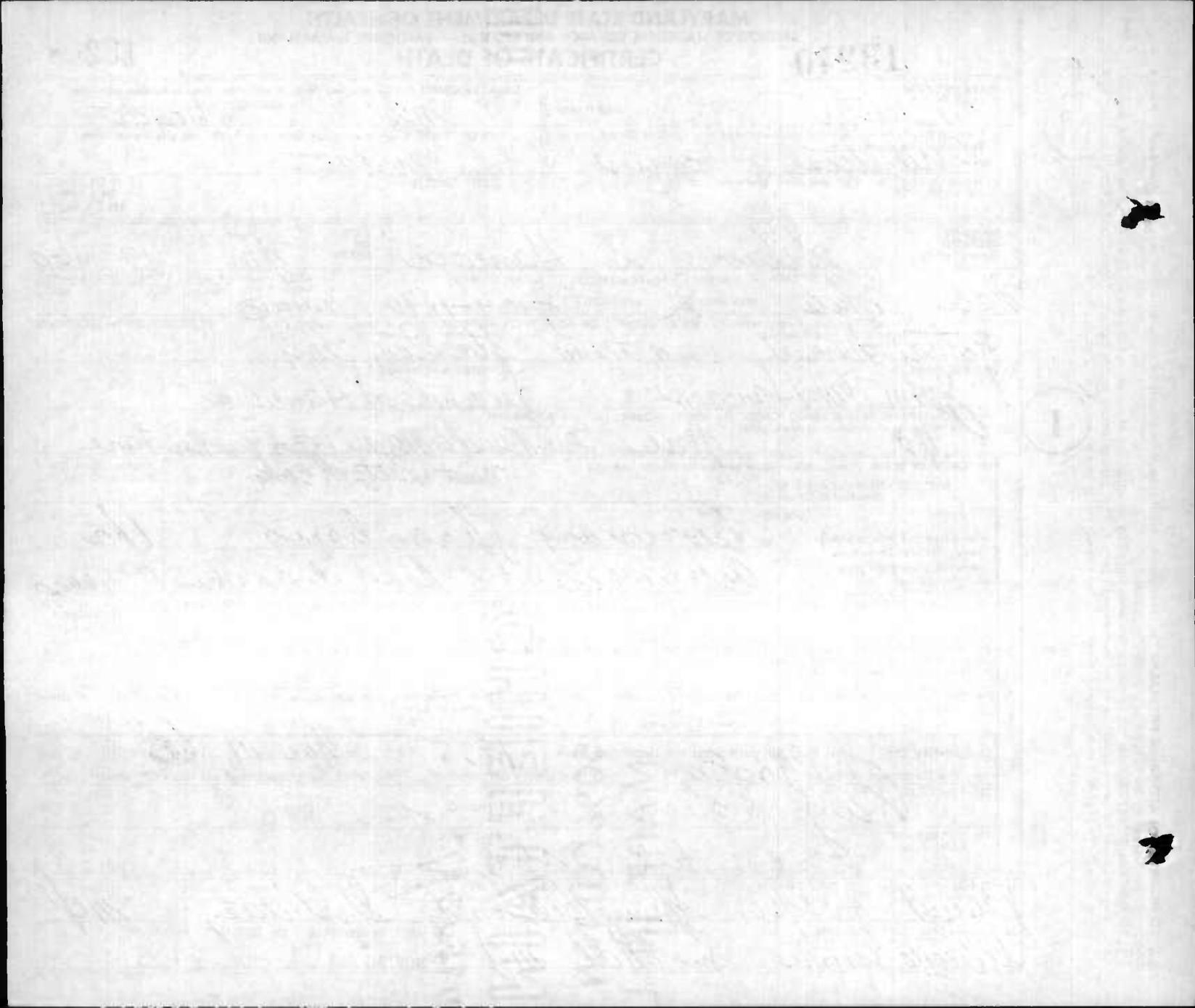
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13208

13240

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. STREET ADDRESS <i>X Hardtice</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Silas S. Hancock</i>		4. DATE OF DEATH <i>Nov. 17 1960</i>	Month Day Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 4-1870</i>		9. AGE (In years last birthday) <i>90 10 00</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Worker, own farm</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Stockton, Md</i>
12. CITIZEN OF WHAT COUNTRY? <i></i>		13. FATHER'S NAME <i>John Wm. Hancock</i>	
14. MOTHER'S MAIDEN NAME <i>Suzinda S. Hancock</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Ms. Maude B. Mayer 143 S. Quaker Lane West Hartford, Conn.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4100</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>		<i>1 hr</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(c)</i>		<i>many years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Paul Cohen</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <i>Snow Hill Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov 20 60</i>		23b. DATE THEREOF <i>Spring Hill Cemetery</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Salisbury Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne E. Lewis</i>		ADDRESS <i>Snow Hill, Md</i>	
25a. REC'D BY REGISTRAR <i>NOV 21 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Caroline S. Krause</i>	

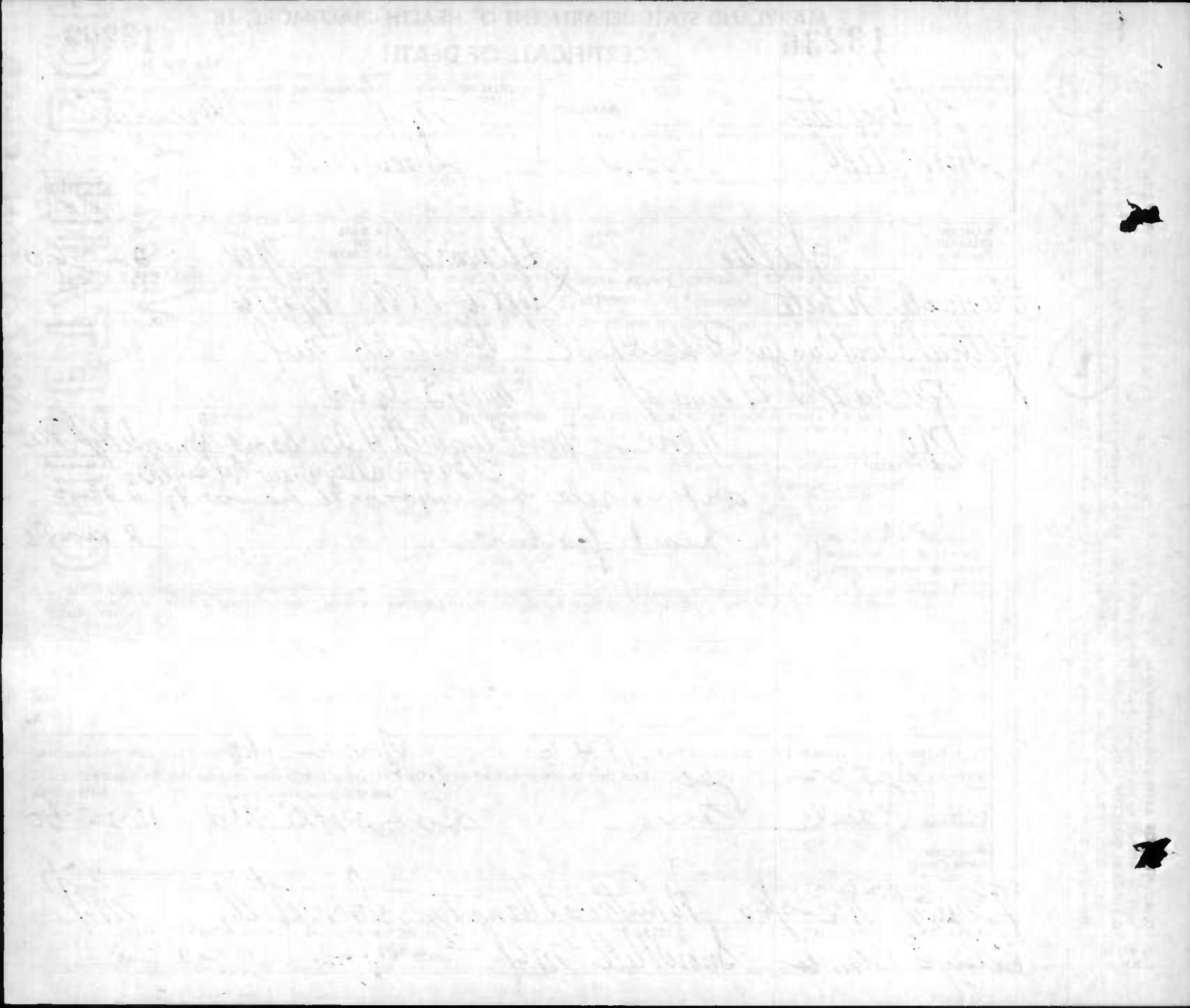


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13236 CERTIFICATE OF DEATH 13209

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		Reg. Dist. No. <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN 1b <i>75 yrs</i>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lillie</i>		First	Middle	Last	4. DATE OF DEATH <i>Nov. 22 1960</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 6-1881</i>	9. AGE (In years day/birthday) <i>79 11/11</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bethel School Teacher Public School</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Arnold, Md</i>	
13. FATHER'S NAME <i>Richard S. Heward</i>		14. MOTHER'S MAIDEN NAME <i>Mary J. Tyler</i>		12. CITIZEN OF WHAT COUNTRY? <i>Springfield Pa.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		INFORMANT <i>Elizabeth H. Jackson</i>	Address <i>264 Valley View Rd, Elizabethtown, Pa.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic myocarditis with 2 year heart failure.</i>				INTERVAL BETWEEN DEATH AND DEATH <i>2 months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>422-1</i>		(b)			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 22 1945</i> , 19 <i>60</i> to <i>Nov 22 1960</i> that I last saw the deceased alive on <i>Nov 22 1960</i> , and that death occurred at <i>9:00 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Snow Hill Md</i>	
ACTUAL SIGNATURE <i>Paul Owen</i>		M.D.		DATE SIGNED <i>11-25-60</i>	
PHYSICIAN'S NAME (Type) <i></i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremated Nov. 25 1960</i>		22b. NAME OF CEMETERY OR CREMATORIUM <i>Whatcoat Cemetery</i>		22d. LOCATION (City, town, or county) <i>Snow Hill</i>	
23. FUNERAL DIRECTOR'S SIGNATURE, <i>Wayne Dennis</i>		ADDRESS <i>Snow Hill Md</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 28 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

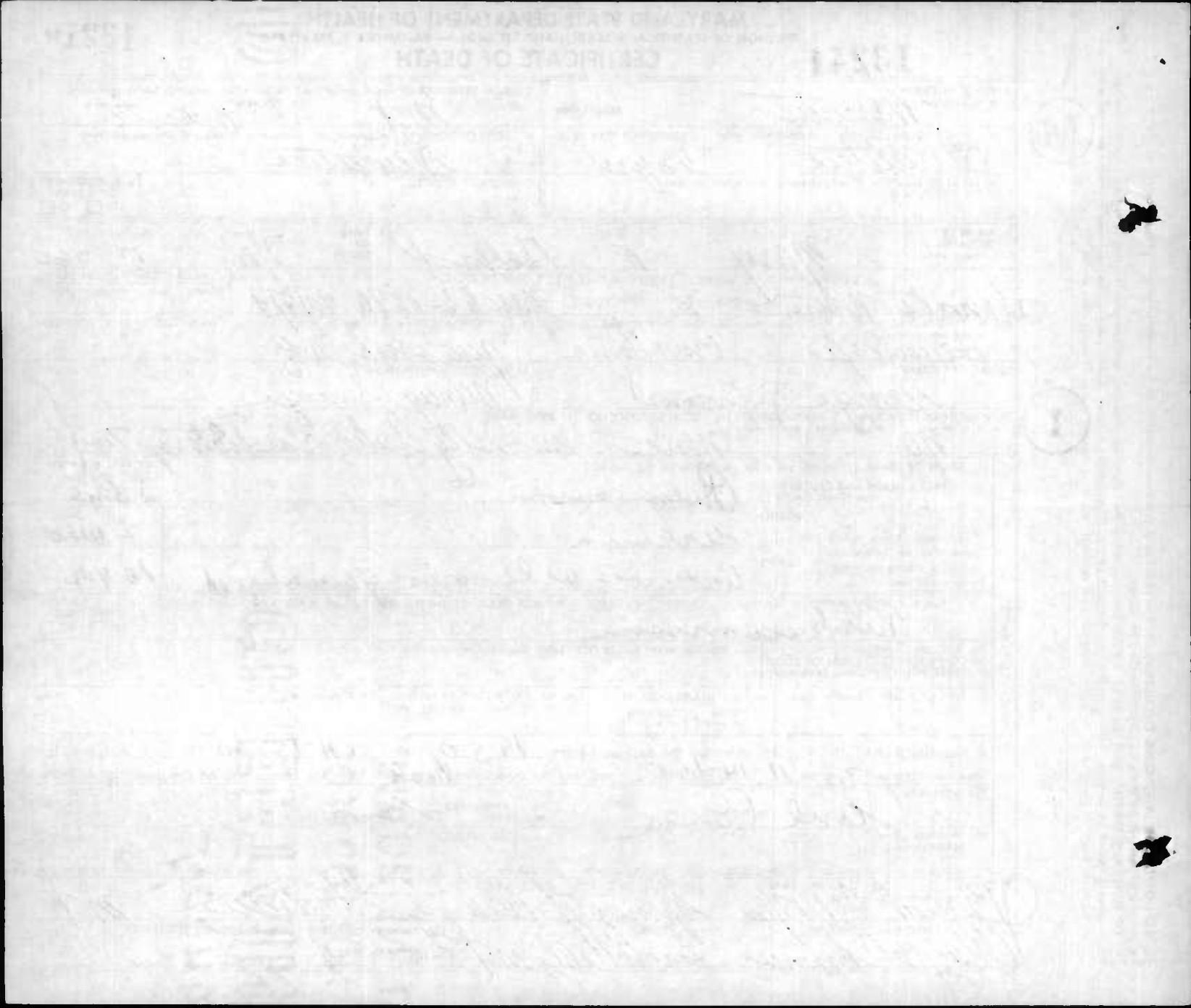
13210

13241

1. PLACE OF DEATH o. COUNTY <i>Worcester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>62 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Mary</i>	Middle <i>F</i>	Last <i>Holland</i>	4. DATE OF DEATH Month <i>Nov.</i> Day <i>15</i> Year <i>1960</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>March 6-1870</i>	9. AGE (In years last birthday) yrs. <i>90 8/9</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Our Home</i>		11. BIRTHPLACE (State or foreign country) <i>New York N.Y.</i>	
13. FATHER'S NAME <i>George R. Evans</i>		14. MOTHER'S MAIDEN NAME <i>Mickey Savage</i>		12. CITIZEN OF WHAT COUNTRY? Address <i>Mrs Dolly Orde, Baltimore Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>2 Who</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>uremia</i> DUE TO (c) <i>Arterio-sclerosis Generalized</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Parkinsonism</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <i>19</i>	Month, Day, Year p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>1950</i> , to <i>11-15-60</i> , 19_____, that (I) (we) lost saw the deceased alive on <i>11-14-60</i> , 19_____, and that death occurred <i>11-15-60</i> AM, from the causes and on the date stated above.				22b. DATE SIGNED	
22a. SIGNATURE <i>Paul Conner</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23d. BURIAL, CREMATION, ETC. DATE THEREOF REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)	
<i>Buried FOX 17/60</i>		<i>Spring Hill Cemetery Snow Hill, MD</i>		<i>Baltimore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne E. Dennis</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>NOV 18 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

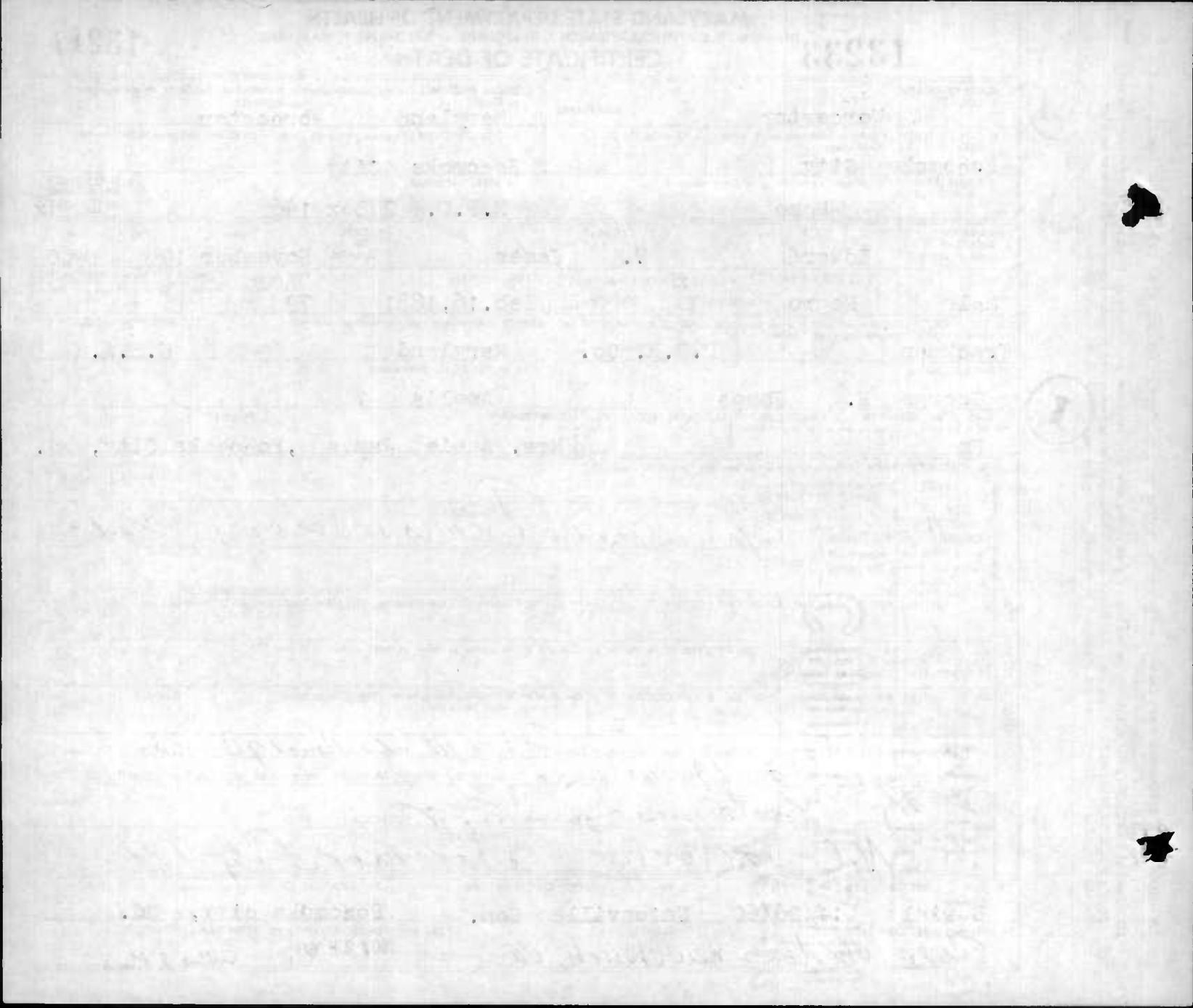
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13233

CERTIFICATE OF DEATH

13211

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS R.F.D.# 2 Box 146		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Edward	Middle V.	Last James	4. DATE OF DEATH	Month November	Day 19	Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1881	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY P.R.R. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George H. James		14. MOTHER'S MAIDEN NAME Amelia ?		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Annie James, Pocomoke City, Md.	INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i> (c) <i>years</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Act 17th Nov 9th 1962</i>	20f. (City or town) <i>Pocomoke City</i>	(County) <i>Md.</i>	(State) <i>Md.</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 17th 1962</i> to <i>Nov 9th 1962</i> , that (I) (we) last saw the deceased alive on <i>Oct 19 1962</i> , and that death occurred at <i>Md.</i> from the causes and on the date stated above.								
22a. SIGNATURE <i>N.E. Sartorius</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>Nov 9th 1962</i>					
22c. PHYSICIAN'S NAME (Type) <i>N.E. Sartorius</i>		22d. ADDRESS <i>Pocomoke City Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/26/60	23c. NAME OF CEMETERY OR CREMATORIAL Unionville Cem.	23d. LOCATION (City, town, or county) Pocomoke city, Md.		(State) <i>Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - Newchurch, Va.</i>	ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 28 '60	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13242

CERTIFICATE OF DEATH

Reg. Dist. No.

13212

1. PLACE OF DEATH a. COUNTY Worcester			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New Jersey		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop RFD			c. LENGTH OF STAY IN 1b 2 Weeks		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXXX			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARGARET			First EDWARDS	Middle NICHOLSON	Last 75
4. DATE OF DEATH NOV. 16	Month Nov.	Day 16	Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 29, 1885	9. AGE (In years lost birthday) yrs. 75	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) England	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Edwards			14. MOTHER'S MAIDEN NAME Mary Ann West		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XX		17. INFORMANT Mrs. Herman Hudson Bishop, Md. RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH at death					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Ocean View	(County) Deleware
21. I certify that I attended the deceased from 11/1 , 19 60 , to 11/16 , 19 60 , that I last saw the deceased alive on 11/16 , 19 60 , and that death occurred at 10 1/2 M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Willian R. Campbell M.D.				ADDRESS (Street, city or town, state) Ocean View Deleware	
DATE SIGNED 11/17/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/60	22c. NAME OF CEMETERY OR CREMATORIUM Arlington	22d. LOCATION (City, town, or county) Merchantville, NJ N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville, Del.		ADDRESS Selbyville, Del.	24a. REC'D BY REGISTRAR Arthur S. Krause	24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
VS A15 (4) 15M 9/59					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13243

CERTIFICATE OF DEATH

Reg. Dist. No.

13213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stackley</i>	c. LENGTH OF STAY IN 1b <i>1 yr 4 mo</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	d. STREET ADDRESS <i>X Snow Hill</i>
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <i>Holland Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Sallie</i>	Middle <i>E.</i>	Last <i>Otten</i>
4. DATE OF DEATH Month <i>Nov.</i>	Day <i>3</i>	Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 22-1890</i>
9. AGE (In years last birthday) <i>70 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	12. BIRTHPLACE (State or foreign country) <i>Hocomoke City, Md</i>
13. FATHER'S NAME <i>Elton S. Sanding</i>	14. MOTHER'S MAIDEN NAME <i>Arletta Redden</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>	INFORMANT <i>Mrs. Wallace Watson 210 Oakwood Rd</i>	Address <i>Bayley Wilmington 3 Del</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 HR</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		ACUTE CORONARY OCCLUSION	
		HYPER TENSIVE CARDIOVASCULAR DISEASE 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Nov 3 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>104 Bay St</i>
21. I certify that I attended the deceased from <i>Aug.</i> , 19 <i>50</i> , to <i>Nov. 3</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Nov 3</i> , 19 <i>60</i> , and that death occurred at <i>6:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert C. LaMar</i>		ADDRESS (Street, city or town, state) <i>Snow Hill, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Robert C. LaMar, M. D.</i>		DATE SIGNED <i>11/4/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov 6 '60</i>		22b. NAME OF CEMETERY OR CREMATORIUM <i>Whitcoat Cemetery</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>May E. Dunn</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill Md</i>	
ADDRESS <i>Snow Hill, Md.</i>		24a. REC'D BY REGISTRAR DATE NOV 7 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

CEMETERY OF GENEVA

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

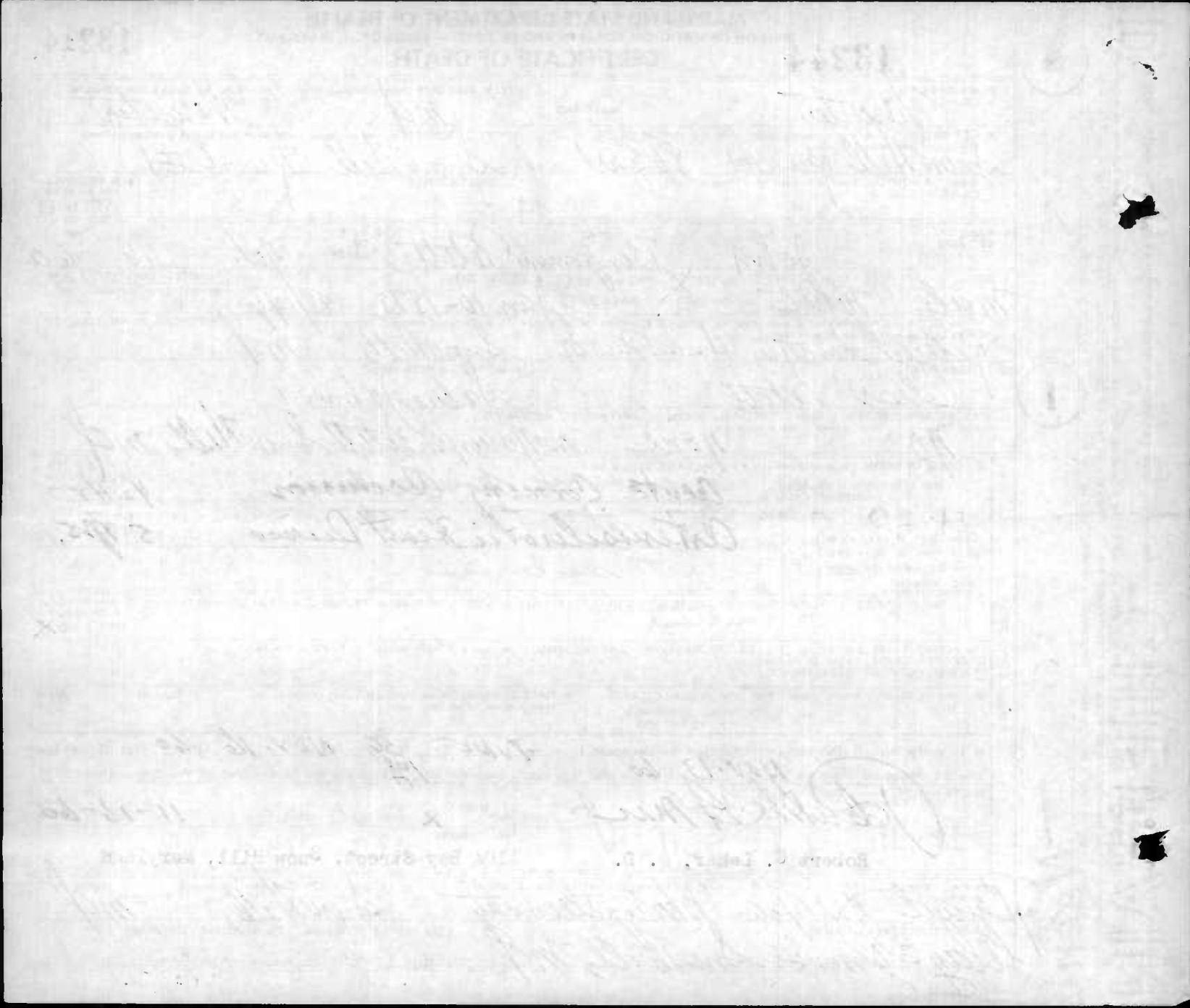
13244

13214

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill Rural #1</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill Rural #1</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year <i>Nov. 16 1960</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 10-1872</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumbed Painter Home Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Snow Hill, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>	
13. FATHER'S NAME <i>Elias Petett</i>		14. MOTHER'S MAIDEN NAME <i>Sallie Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mary & Petett Snow Hill, MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> DUE TO <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 HR</i> <i>5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> , 1956, to <i>Nov. 16</i> , 1960, that (I) (we) last saw the deceased alive on <i>Nov. 13</i> , 1960, and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>11-16-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert C. LaMar, M. D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>104 Bay Street, Snow Hill, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov. 18 1960</i>		23b. DATE THEREOF <i>Nov. 18 1960</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Methodist Cemetery</i>		23d. LOCATION (City, town, or county) <i>Snow Hill, MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Play & Sonner Snow Hill, MD</i>		ADDRESS	
		25a. REC'D BY REGISTRAR DATE <i>Nov 18 1960</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4a may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13228

13215

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>maryland</i>		b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		c. LENGTH OF STAY IN 1b <i>2 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		d. STREET ADDRESS <i>R. F. D.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>MARIE</i>	Middle <i>A.</i>	Last <i>RAYNE</i>	4. DATE OF DEATH Month <i>Nov.</i> Day <i>23</i> Year <i>1960</i>	Month <i>Nov.</i> Day <i>23</i> Year <i>1960</i>	IF UNDER 1 YEAR Months <i>82</i> yrs.	IF UNDER 24 HRS. Hours <i>36 hrs.</i> Min.
S. SEX <i>F</i>	6. COLOR OR RACE <i>WC</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 18, 1878</i>	9. AGE (In years lost birthday) <i>82</i> yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>VILLARDS MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>FREDERICK MITCHELL</i>		14. MOTHER'S MAIDEN NAME <i>THEODOSSIA WELLS</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mrs LESTER BRITTINGHAM, BERLIN MD.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Degenerative Heart Disease</i> DUE TO DUE TO (b) <i>Senility</i> (c) <i>Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 "</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>11-19 1969a</i>		20f. (City or town) (County) (State) <i>11-23 1960</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>11-19 1969a</i> to <i>11-23 1960</i> , that (I) last saw the deceased alive on <i>11-23 1960</i> and that death occurred <i>3 PM</i> , from the causes and on the date stated above.								
22a. SIGNATURE <i>Ivory U. Sully, Jr.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11-25-60</i>				
22c. PHYSICIAN'S NAME (Type) <i>Ivory U. Sully, Jr. MD</i>		22d. ADDRESS <i>Berlin, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/26/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>New Hope</i>		23d. LOCATION (City, town, or county) (State) <i>VILLARDS MD</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Bruno A. Burbage</i>		ADDRESS <i>Berlin Md</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 28 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13216

13245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Showell		c. LENGTH OF STAY IN lb 50 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Showell					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX		d. STREET ADDRESS XX				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ORLANDO		First MACK	Middle SHOCKLEY	Lost	4. DATE OF DEATH Nov. 17	Month Nov.	Day 17	Year 1960	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 7, 1875	9. AGE (In years from birthday) yrs. 85	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canner		10b. KIND OF BUSINESS OR INDUSTRY Tomato canner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Shockley		14. MOTHER'S MAIDEN NAME Ellen Shockley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. 220-09-1404		17. INFORMANT Mrs. Edith Palmer		Address Showell, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X Conditions, if any, which gave rise to immediate cause (a), slotting the under-lying cause lost. (b) (c)		DUE TO <i>Acute myocarditis</i> <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH ?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-15-60 , 19_____, to 11-17-60 , 19_____, that I last saw the deceased alive on 11-17-60 , 19_____, and that death occurred at 11-17-60 , 19_____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Clifford E. Schott M.D.					
ACTUAL SIGNATURE Clifford E. Schott		PHYSICIAN'S NAME (Type) Dr. Clifford E. Schott		DATE SIGNED Clifford E. Schott M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/60		22c. NAME OF CEMETERY OR CREMATORIAL 1202 O.E.		22d. LOCATION (City, town, or county) Bishopville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Salliville, Del.		ADDRESS Peter Whaley Salliville, Del.		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE NOV 22 '60	

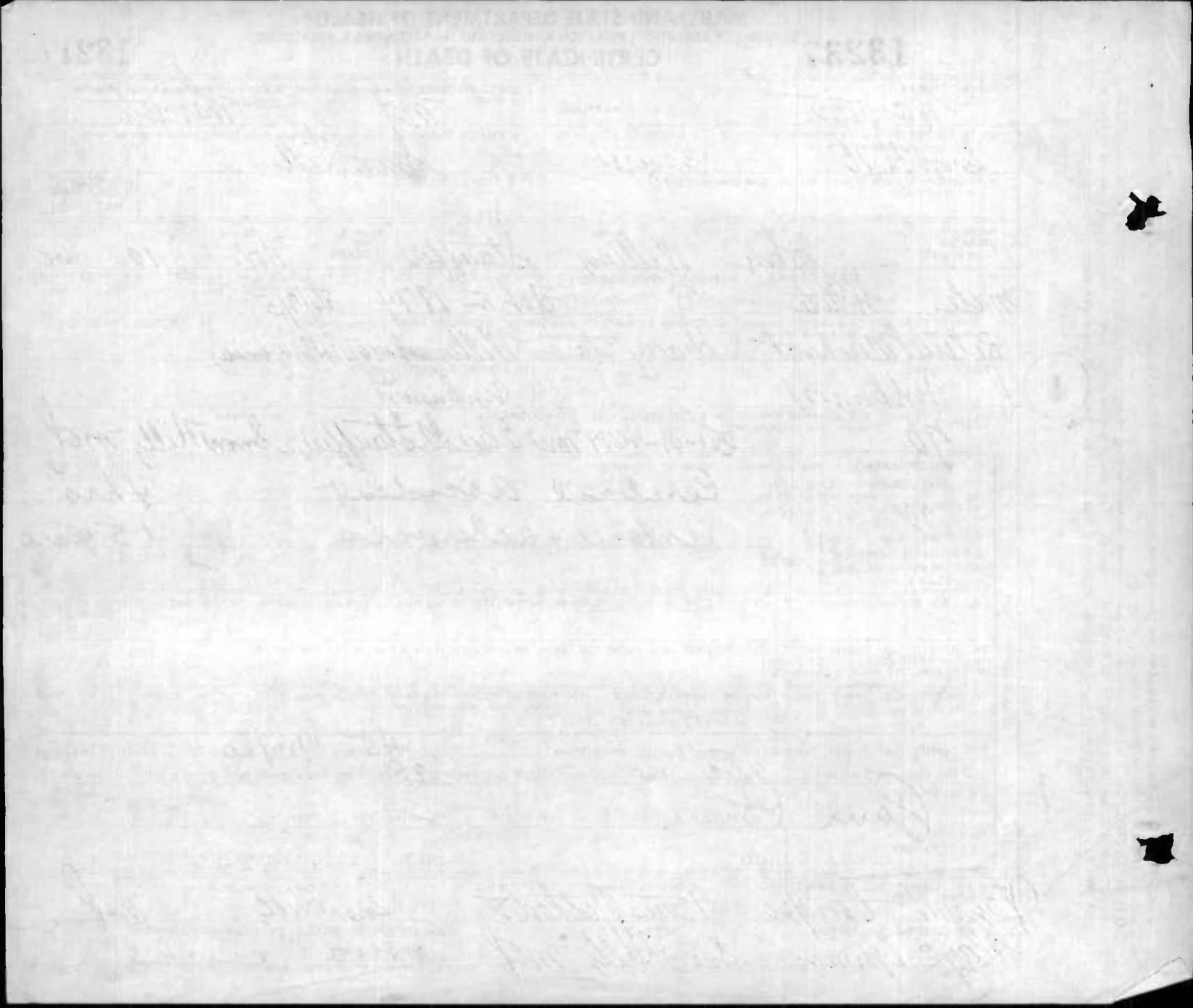
CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM HENRY COOPER	AGE 60	SEX M	DEATH DATE 1950-01-01	TIME 10:00 AM
ADDRESS 1234 FAIRFIELD DR.	PLACE OF DEATH HOME	CAUSE OF DEATH HEART DISEASE	DIAGNOSIS HYPERTENSION	RELEASER DR. JAMES M. COOPER
RELATIONSHIP SON	DEATH CERTIFICATE NUMBER 1234567890	DATE ISSUED 1950-01-01	ISSUING CLERK JANE DOE	APPROVING PHYSICIAN DR. JAMES M. COOPER
I declare under penalty of perjury that the foregoing is true and correct. WITNESS: WILLIAM HENRY COOPER Signature: WILLIAM HENRY COOPER Address: 1234 FAIRFIELD DR. Date: 1950-01-01				

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												13217	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Worcester</i>						2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>						b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>			c. LENGTH OF STAY IN 1b <i>30 yrs</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>			d. STREET ADDRESS <i>X Snow Hill</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION													
3. NAME OF DECEASED (Type or print)		First <i>John</i>		Middle <i>William</i>		Last <i>Stauffer</i>		4. DATE OF DEATH <i>Nov. 10 1960</i>		Month Day Year			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 6 1874</i>		9. AGE (In years from birthday) <i>86 yrs</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bellied Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bracey Store</i>		11. BIRTHPLACE (State or foreign country) <i>Williamsburg Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i>							
13. FATHER'S NAME <i>John Stauffer</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>91-01-4679</i>		17. INFORMANT <i>Mrs Elsie G. Stauffer, Snow Hill MD</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Cerebral accident</i>										INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO <i>Arterio-sclerosis</i>		(c) DUE TO <i>Arterio-sclerosis</i>								15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Snow Hill</i>		(County) <i>Snow Hill</i>		(State) <i>MD</i>			
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ P.M., from the causes and on the date stated above.													
22a. SIGNATURE <i>Paul Cohen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <i>11/10/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>Paul Cohen</i>		22d. ADDRESS <i>Snow Hill, Maryland</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov 13/60</i>		23b. DATE THEREOF <i>Nov 13/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Methodist</i>		23d. LOCATION (City, town, or county) <i>Snow Hill</i>		(State) <i>MD</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>George Dennis</i>		ADDRESS <i>Snow Hill, MD</i>				25a. REC'D BY REGISTRAR <i>NOV 14 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13234

CERTIFICATE OF DEATH

13218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 18 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 704 Second Street		d. STREET ADDRESS 704 Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First HARRY	Middle FULLER	Last WALLS	4. DATE OF DEATH November	Month 12,	Day 1960	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 18, 1879	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail Clothing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel L. Walls				14. MOTHER'S MAIDEN NAME Emma Lambden				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs Hattie M. Walls, 704 Second Street, Pocomoke City, Md.				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE</p> <p>DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 420.</p> <p>(b) HYPERTENSIVE CARDIO VASCULAR DISEASE 15 YEARS</p> <p>DUE TO (c) ATHROSCLEROTIC VASCULAR DISEASE 20 YEARS</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pocomoke City, Worcester, MD.	20f. (City or town) Pocomoke City, Worcester, MD.	(County) Worcester	(State) MD.	
<p>21. I certify that I attended the deceased from OCT. 26, 1959, to NOV. 12, 1960, that I last saw the deceased alive on OCT. 13, 1960, and that death occurred at 12 PM, from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) 212 MARKET ST. NOV. 12, 60</p> <p>DATE SIGNED C. STANFORD HAMILTON, M.D.</p> <p>ACTUAL SIGNATURE C. STANFORD HAMILTON, M.D.</p> <p>PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON, POCOMOKE CITY, MD.</p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-14-60	22c. NAME OF CEMETERY Maple Wood Cemetery	22d. LOCATION (City, town, or county) Wilson, North Carolina	(State) NC				
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson		ADDRESS Pocomoke City, Md.	24a. REC'D BY REGISTRAR Arthur S. Hause	24b. REGISTRAR'S SIGNATURE Arthur S. Hause				
			DATE NOV 15 '60					

